

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8-2

CERTIFICATE OF DEATH

01055
Reg. Dist. No. 350

1. PLACE OF DEATH:

County WorcesterCity or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 60 yearsHospital, institution, or street address where death occurred: —How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)Street No. Market Street
(If rural, give LOCATION)2.(a) If veteran, name war —

3. (a) FULL NAME

Katie Adkins

3. (b) Social Security Number

—

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

Aug 31-1865

8. AGE:

Years

Months

Days

If less than one day

80420

hrs. min.

9. Birthplace

Sabersburg, Worcester, Maryland
(City, town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

R. F. Adkins

FATHER

12. Name

Maryland

13. Birthplace

Katie Savage

14. Maiden name

Virginia

15. Birthplace

16. Informant

Mr. Earl H. Stevens

Address

Snow Hill Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan 24-1946
(month) (day) (year)

Cemetery or crematory

Presbyterian Cemetery

Location

Pocomoke Md.

18. Funeral director

Margarette Skudatani

Address

Pocomoke Md.

19.

(Date rec'd by registrar)

19 46Anne E. White
Registrar

MEDICAL CERTIFICATION

A. M.

20. DATE OF DEATH January 21st, 1946 at 11:30 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 16th, 1946 to 1/21st/1946.and that I last saw him alive on January 21st, 1946Immediate cause of death Physical exhaustion

DURATION

5 daysDue to Cerebral hemorrhage5 daysDue to Arteriosclerosis due to age(?)Other conditions Has been blind for a period of about ten years.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury —Injured at work? —

23. SIGNATURE

R. Lee Hae

M. D. or other

Address Pocomoke City Md. Date signed 1/22/46

RECEIVED

JAN 25 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

CERTIFICATE OF DEATH

01056 355
Reg. Dist. No.

1. PLACE OF DEATH:

County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred RFD

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WorcesterCity or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. RFD
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

CHARLES H. BASSETT

3. (b) Social Security Number

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 24 1863

8. AGE: Years Months Days If less than one day

82 5 6 hrs. min.9. Birthplace BERLIN WOR. Co. MD
(Town, county, and state)10. Usual occupation FARMER

11. Industry or business

12. Name BENJAMIN BASSETT13. Birthplace MD.14. Maiden name JULIA ANN BARNES15. Birthplace MD16. Informant MRS. WILLIAM BASSETTAddress SALISBURY MD17. BURIAL Date thereof 2/1/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory EVERGREENLocation BERLIN, MD18. Funeral director Anna A. BurboysAddress Berlin Md.19. 2-1- 1946 Helen F. Hayward
(Data rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 30 1946 at 12 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 25 1946 to Jan 30 1946and that I last saw him alive on Jan 30 1946Immediate cause of death Coronary Occlusion

DURATION

5 daysDue to Generalized arteriosclerosis 30 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. F. Hayward M. D. or otherAddress Berlin Date signed 2/1/46

RECEIVED

FEB 7 1946

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01057 353

1. PLACE OF DEATH:

County HarfordCity or town Bishopville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Bishopville
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

Almira Bunting

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Elisha M. Bunting7. Birth date of deceased (mo., day, yr.) Dec 11 18746. (c) If alive, give age 77 years8. AGE: Years 71 Months 1 Days 20 If less than one day

hrs. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Housework12. Name Elisha Bunting13. Birthplace md.14. Maiden name Nancy Bunting15. Birthplace md.16. Informant John BuntingAddress Bishop, Md.17. Burial Date thereof Jan 27 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory D.O.C. 97Location Bishopville, Md.18. Funeral director M. Pasha WatsonAddress Sellersville, Del.19. Jan 26 46 Mrs. Roy Bury

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 24 19 46 at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 19 43 to Jan 24 19 46and that I last saw him alive on Jan. 24 19 46Immediate cause of death Diabetes mellitus, severe

DURATION

3 yrs.Due to arterio-sclerotic heart disease5 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert H. Long

M. D. or other

Address Frankford, Del. Date signed 1-26-46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

LOCAL BOARD OF HEALTH

STATE OF MASS.

MEDICAL EXAMINER

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 933

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County..... Worcester
 City or town..... RURAL, Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 2 years
 Hospital, institution, or street address where death occurred:
Rt 2
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Somerset
 City or town..... RURAL Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
Rt 1
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

William Henry Hayward

3. (b) Social Security Number

4. Sex..... Male 5. Color or race..... Colored 6.(a) Single, married, widowed, or divorced..... widowed
 6.(b) Name of husband or wife..... Nester York Hayward
 7. Birth date of deceased (mo., day, yr.)..... March 21, 1898 6.(c) If alive, give age..... years
 8. AGE: Years..... 67 Months..... 10 Days..... 0 If less than one day..... hrs. min.

9. Birthplace..... Somerset County - Maryland
(Town, county, and state)10. Usual occupation..... Farmer

11. Industry or business

FATHER 12. Name..... Harry Hayward
 13. Birthplace..... Somerset County, Md
 MOTHER 14. Maiden name..... Malinda Miles
 15. Birthplace..... Somerset County Md
 16. Informant..... Malinda Hayward
 Address..... Pocomoke City Md #Rt 3

17. Burial..... Burial Date thereof..... Jan. 25, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Waters Private Cemetery
 Location..... RURAL, Pocomoke City, Md

18. Funeral director..... H. Harven Bradshaw
 Address..... Pocomoke City, Md.

19. Jan 25 1946 Anne E. White
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Jan 21st 1946, at 4:30 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19th 46 to Jan 21st 46
 and that I last saw him alive on Jan 19th 46
 Immediate cause of death..... Heart failure due to chronic myocarditis DURATION..... 2 days
chronic myocarditis J.R.
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE..... J.E. Antorinus Md.
 Address..... Pocomoke City Md. M. D. or other
 Date signed..... 1/29/46

RECEIVED

JAN 28 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

01059

★ Reg. Dist. No. 355

1. PLACE OF DEATH:

County..... Worcester
 City or town..... Hallowville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 22 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? ✓

3. (a) FULL NAME

Sally Taylor Lewis

3. (b) Social Security Number

216-18-2672

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Benjamin Edward Lewis
 7. Birth date of deceased (mo., day, yr.) Dec 25, 1873. 8. (c) If alive, give age 81 years

8. AGE: Years 72 - 0 + 9 Days hrs. min.

9. Birthplace Worcester Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Housework

12. Name Bill Taylor

13. Birthplace Md.

14. Maiden name Mariah Gorman

15. Birthplace Md.

16. Informant Beulah Lewis

Address Hallowville, Md.

17. Burial, cremation, or removal (Which?) Burial Date thereof Jan 6, 1946 (month) (day) (year)

Cemetery or crematory Hallowville

Location Hallowville, Md.

18. Funeral director M. Asha Watson

Address Selbyville, Del.

19. Jan 6, 1945 Helen F. Hayward

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Hallowville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2. (a) If veteran, name war

216-18-2672

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3, 1946 at 7:04 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2, 1946 to Jan 3, 1946 and that I last saw her alive on Jan 3, 1946.

Immediate cause of death Coronary thrombosis

DURATION

12 hrs.

Due to

Due to

Other conditions arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Frank P. Lewis Md.

Address Willards Md. Date signed 1-3-46

M. D. or other

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
JAN 7 1946
BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 480

01060

CERTIFICATE OF DEATH

Reg. Dist. No. 357

1. PLACE OF DEATH:

County Worcester
 City or town Snow Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 21 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Snow Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Elmer M. Mason

7. Birth date of deceased (mo., day, yr.) March 25 - 1892 6. (c) If alive, give age 65 years

8. AGE: Years 53 Months 9 Days 10 If less than one day _____ hrs. _____ min.

9. Birthplace Worcester, Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

12. Name John S. Spining

13. Birthplace Maryland

14. Maiden name Esther Lehigh

15. Birthplace Maryland

16. Informant M. Elmer M. Mason

Address Snow Hill, Md.

17. (Burial, cremation, or removal, which?) Burial Date thereof Jan 7/46
 (month) (day) (year)

Cemetery or crematory Bates Memorial

Location Snow Hill, Md.

18. Funeral director Heame & Son

Address Snow Hill, Md.

19. (Date rec'd by registrar) 1/7/46 Registrar LeRoy Smith

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 19 46 at 7:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 19 45 to January 3 19 46

and that I last saw him alive on January 4 19 46

Immediate cause of death Anemia + Cachexia

Due to Uterine Carcinoma

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert L. Mason, M.D.

Address Snow Hill Date signed 1-7-46

RECEIVED

JAN 10 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 837

CERTIFICATE OF DEATH

01061353
Reg. Dist. No.

1. PLACE OF DEATH:

County Worcester
City or town Whaleyville, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
State Md. County Worcester
City or town Whaleyville, Md. Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Henry Moore

3. (b) Social Security Number

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced

8.(b) Name of husband or wife Bele Moore
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 11, 1871

8. AGE: Years 74 Months 4 Days 5 If less than one day
..... hrs. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business

12. Name Bill Moore

13. Birthplace Md.

14. Maiden name Jane Townsend

15. Birthplace Md.

16. Informant Kate Showell

Address Berlin, Md.

17. Burial Date thereof Jan. 19, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Longs Cem.

Location Sublyville, Del.

18. Funeral director Margaret W. Watson

Address Pocomoke City, Md.

19. Jan 19 46 Mrs. Roy Bergery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 16 1946 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1946 to Jan 16 1946
and that I last saw him alive on Jan 16 1946

Immediate cause of death Cerebral Hemorrhage DURATION 12 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. E. James M. D. or other

Address Sublyville, Del. Date signed 1-17-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 29 1946
BUREAU V. B.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01062

353

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Worcester
 City or town..... Near Salisbury Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Oscar Dewey Mumford

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced.....

maleCol

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

Aug. 21, 1899

8. AGE:

Years

Months

Days

If less than one day

4656

hrs

min.

9. Birthplace.....

Bishop, Md.
(Town, county, and state)

10. Usual occupation.....

Farming

11. Industry or business.....

FATHER

12. Name.....

Isaac Mumford

13. Birthplace.....

Md.

MOTHER

14. Maiden name.....

Inez Hallford

15. Birthplace.....

Md.

16. Informant.....

Ephraim Mumford

Address.....

Salisbury Del17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

Jan. 30, 1946
(month) (day) (year)

Cemetery or crematory.....

Sarah Duker Bishop, Md.

Location.....

18. Funeral director.....

Marguerite H. Watson

Address.....

Pocomoke City, Md.19. Jan 30

(Date rec'd by registrar)

Mealy Benson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... WorcesterCity or town..... Near Salisbury Del

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Jan 2719 46 at 1 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.....

to.....

19.....

and that I last saw him..... alive on.....

19.....

Immediate cause of death.....

Stab wound of heart

DURATION

5 min

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

homicide

Date of.....

Jan 27

Where did injury occur?

near Salisbury Worcester

(City or town)

(County)

(State)

Md

Injured at home, farm, industry, public place (where?)

Means of injury.....

Stab wound

Injured at work?

No

23. SIGNATURE.....

John L. Riley Sup. Med. Exam

M. D. or other

Address.....

Brown Hill Md

Date signed.....

1/27/46

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JAN 31 1946

BUREAU V R

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

01063

CERTIFICATE OF DEATH

Reg. Dist. No. 357

1. PLACE OF DEATH: *Worcester*
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name War.....

3. (a) FULL NAME *Elisah Albert Perdue*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Divorced*

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *March 20 - 1863* 6. (c) If alive, give age..... years

8. AGE: Years *83* Months *9* Days *36* It less than one day..... hrs. min.

9. Birthplace *Pittsville, Wisconsin, Wis.*
 (Town, county, and state)

10. Usual occupation *Retired Merchant*11. Industry or business *Grace's Store*12. Name *John B. Perdue*13. Birthplace *Maryland*14. Maiden name *Margaret Ellis*15. Birthplace *Maryland*16. Informant *Mrs. Ida B. Adkins*Address *Snow Hill, Md.*17. (Burial, cremation, or removal, which?) *Rural* Date thereof *Jan. 19/46*Cemetery or crematory *Watson*Location *Snow Hill, Md.*18. Funeral director *Hearne & Damm*Address *Snow Hill, Md.*19. (Date recd by registrar) *1/18/46* Registrar *LaRay Smith*

MEDICAL CERTIFICATION

20. DATE OF DEATH *January 16* 19 *46* at *11 P.* M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *March 15* 19 *45* to *January 16* 19 *46*
 and that I last saw him alive on *January 8* 19 *46*

Immediate cause of death *Acute Pulmonary edema*
 Due to *congestive cardiac failure*
 Due to *hypertensive cardiomyopathy*
 Other conditions *chronic disease*
 (Include pregnancy within 8 months of death)

DURATION

*1 day**6 wks**5 years*

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE *Robert L. LeMay, M.D.* M. D. or otherAddress..... Date signed *1/17/46*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 19 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01664



Reg. Dist. No. 351

1. PLACE OF DEATH:
 County Worcester
 City or town Snow Hill
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 1/2 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town Snow Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION) 70
 2.(a) If veteran, name war _____

3. (a) FULL NAME George E. Powell

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Betty Powell
 6. (c) If alive, give age 73 years
 7. Birth date of deceased (mo., day, yr.) Feb 24 1966
 8. AGE: Years 79 Months 10 Days 22 It less than one day _____ hrs. _____ min.

9. Birthplace Snow Hill Md
 (Town, county, and state)
 10. Usual occupation Robert

11. Industry or business

12. Name George E. Powell
 13. Birthplace Snow Hill Md
 14. Maiden name Charlotte Dryden
 15. Birthplace Snow Hill Md

16. Informant Mrs George Shockey

Address Snow Hill, Md

17. Burial Date thereof Jan. 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Whatcoat

Location Snow Hill, Md

18. Funeral director Hearne & Dinnis

Address Snow Hill, Md

19. 11/8/46 46 LeRoy Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 1946 at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19____, to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death Perforated duodenum

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? No23. SIGNATURE John L. Remy Sup. Med Exam

M. D. or other

Address Snow Hill Md Date signed 11/17/46

CERTIFICATE OF DEATH

RECEIVED

JAN 19 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01065 350

1. PLACE OF DEATH:

County WorcesterCity or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred: —How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)Street No. —
(If rural, give LOCATION)2.(a) If veteran, name war —

3.(a) FULL NAME

Nancy Quinn

3.(b) Social Security Number

—4. Sex Female5. Color or race Colored6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Robert Quinn6.(c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) Unknown8. AGE: 80+ Years Months Days If less than one day80+ Years Months Days If less than one day9. Birthplace Pocomoke Worcester Md.
(town, county, and state)10. Usual occupation Housewife11. Industry or business —12. Name Unknown13. Birthplace "14. Maiden name Unknown15. Birthplace "16. Informant Samuel Benston (Son)Address Pocomoke Md.17. Burial Date thereof Jan 13/46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Halls Hill CemeteryPocomoke18. Funeral director Margaretta BludworthAddress Pocomoke Md.19. Jan. 15, 1946 Anne E. White

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9, 1946 at 3:59 M

21. I CERTIFY that death occurred on the date above stated that attended deceased from

Jan 3rd 1946 to Jan 7, 1946and that I last saw her alive on Jan 6th 1946Immediate cause of death Shock

DURATION

Being informed of husband's deathDue to SuddenDue to —Other conditions C. MyocarditisGravidity 1st time years

(Include pregnancy within 8 months of death) weeks

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. E. Antonius Md.Address Pocomoke City Md. Date signed 1/13/46

RECEIVED

JAN 17 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01066

Reg. Dist. No. 350

1. PLACE OF DEATH: Worcester
 County Pocomoke City
 City or town Worcester
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 1/2
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town near Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. -
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME Robert L. Linn

3. (b) Social Security Number -

4. Sex male 5. Color or race coed 6. (a) Single, married, widowed, or divorced married
 8. (b) Name of husband or wife Marion Linn

9. (c) If alive, give age 82 years
 7. Birth date of deceased (mo., day, yr.) Unknown 1861

8. AGE: 82 Years Months Days If less than one day
hrs. min.

9. Birthplace Pocomoke City
 (Town, county, and state)
Lobour

10. Usual occupation -

11. Industry or business Unknown

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden name Unknown

15. Birthplace "

16. Informant Samuel Beniston
 Address Pocomoke Md.

17. Burial Date thereof Jan 6-1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. John's Cemetery

Location Rural Pocomoke Md.

18. Funeral director Margaretta St. John
 Address Pocomoke City Md.

19. Jan 5 19 46 Anne E. White
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 19 46 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Myocardial degeneration of heart

22. DURATION Unknown

Other conditions -

Other conditions -

Other conditions -

Other conditions -

Other conditions -

Other conditions -

Other conditions -

Other conditions -

Other conditions -

Other conditions -

Other conditions -

Other conditions -

Other conditions -

Other conditions -

RECEIVED
JAN 7 1946
BUREAU V.A.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-6)

CERTIFICATE OF DEATH

Reg. Diet. No. 355

1. PLACE OF DEATH:

County Worcester
 City or town Berlin R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 80 years
 Hospital, institution, or street address where death occurred: 8
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Worcester
 City or town Berlin
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Margaret Hester Payne

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Parker S. Payne

7. Birth date of deceased (mo., day, yr.) June 29, 1863 6. (c) If alive, give age 88 years

8. AGE: 82 Years 6 Months 21 Days If less than one day _____ hrs. _____ min.

9. Birthplace Berlin Wor. Co. Md R.F.D.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Stephen Hadder

13. Birthplace Maryland

14. Maiden name Rebecca Reed

15. Birthplace Maryland

16. Informant Mrs. John Lounsbury

Address Berlin Md R.F.D.

17. Burial Date thereof 1/25/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Riverside

Location Berlin Md R.F.D.

18. Funeral director Anna A. Bunbury

Address Berlin Md.

19. 1-23 46 Helen L. Hayward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20 1946 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____
 and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____ DURATION _____

Chr. Nephritis

Due to _____

Due to _____

Other conditions Chr. Myocarditis
 (Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Chas. R. Law
 M. D. or other _____

Address Berlin Md. Date signed 1-21-46

MARGIN RESERVED FOR BINDING

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 24 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:

County WorcesterCity or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 73 yearsHospital, institution, or street address where death occurred: ✓How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Pocomoke
(If outside city or town limits, write RURAL and give nearest town)Street No. ✓
(If rural, give LOCATION)2(a) If veteran, name war ✓

3. (a) FULL NAME

James L. Roberts

3. (b) Social Security Number

4. Sex Male5. Color or race Colored6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Sarah J. Robert7. Birth date of deceased (mo., day, yr.) Feb 10, 1851
8. (c) If alive, give age 94 years8. AGE: 94 Years 11 Months 21 Days ✓ If less than one day ✓ hrs. ✓ min.9. Birthplace Atlantic Ocean, Virginia
(Town, county, and state)10. Usual occupation Labour11. Industry or business ✓12. Name William Roberts13. Birthplace Virginia14. Maiden name Unknown15. Birthplace Glenn, Disberson16. Informant FuneralAddress Pocomoke Md.17. Burial Date thereof Feb - 3 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Stalls Hill CemeteryLocation Rural Pocomoke Md.18. Funeral director Marguerite L. W. WhiteAddress Pocomoke Md.19. Feb 4 19 46 Anne E. White
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 31, 1946 at 5:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 29, 1946 to Jan 30, 1946
and that I last saw him alive on Jan 29th 19 46Immediate cause of death Heart failureDue to Central Nervous SystemDue to ArteriosclerosisOther conditions 97

(Include pregnancy within 3 months of death)

Major findings of operations 2 daysAutopsy results years

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of ✓

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ✓ Injured at work?23. SIGNATURE J. P. PartonAddress Pocomoke City Date signed Feb 4, 1946

RECEIVED
FEB 6 1946
BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Plat. No. 350

1. PLACE OF DEATH:

County Worcester
 City or town near Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Worcester
 City or town near Pocomoke City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(c) If veteran, name war _____

3. (a) FULL NAME

James S. Small
 4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 8.(b) Name of husband or wife Arietta Small

6.(c) If alive, give age 78 years
 7. Birth date of deceased (mo., day, yr.) Nov 7, 1868

8. AGE: Years 77 Months 2 Days 12 It less than one day _____ hrs. _____ min.

9. Birthplace Massville Accomack Co.
 (Town, county, and state)
Virginia

10. Usual occupation _____

11. Industry or business _____

12. Name Marcellus Small

13. Birthplace Virginia

14. Maiden name Sallie Russell

15. Birthplace Virginia

16. Informant Robley Small

Address Pocomoke Md.

17. Burial Date thereof Jan 21, 1946
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Halls Hill Cemetery

Location Pocomoke Md.

18. Funeral director Margaret Watson

Address Pocomoke Md.

19. Jan 21 1946 Anne E. White
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 19, 1946 19____ at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John L. Riley Dep. Med. Exam M. D. or other

Address Shore Hills Md. Date signed 1/19/46

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C.

RECEIVED

RECEIVED

JAN 23 1946

BUREAU VS.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1226)

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County... Worcester
 City or town... Berlin md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... Life
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution?... no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... md County... Worcester
 City or town... Berlin md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... no
 (If rural, give LOCATION) no
 2.(a) If veteran, name war... no

3. (a) FULL NAME

Mira E Smith

3. (b) Social Security Number

no

4. Sex... Female 5. Color or race... a.a. 6.(a) Single, married, widowed, or divorced... Single
 8.(b) Name of husband or wife... no 6.(c) If alive, give age... no years
 7. Birth date of deceased (mo., day, yr.)... about 1900
 8. AGE: Years... about 46 Months... — Days... — If less than one day... — hrs. — min.

9. Birthplace... Berlin md
 (Town, county, and state)
 10. Usual occupation... Housekeeper
 11. Industry or business... Same as above
 12. Name... Harry Smith
 13. Birthplace... Berlin md
 14. Maiden name... Sarah Marshall
 15. Birthplace... Berlin md

16. Informant... Ernest Smith
 Address... Berlin md
 17. Burial... Burial Date thereof... Jan 29 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Evergreen
 Location... Berlin md
 18. Funeral director... James P. Stewart
 Address... Salem Md
 19. 1-28... 46 Helen F. Hayward
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Jan 24 1946 at 6-35 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1946 to Jan 24 1946
 and that I last saw him alive on Jan 23 1946
 Immediate cause of death... Int. Obstruction DURATION 2 wks
 Due to... Adhesions, Cong.
Not due to cancer
 Due to...
 Other conditions...
 (Include pregnancy within 3 months of death)

Major findings of operations...
 Date of op...
 Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE... Clifford E. Schatt M. D. or other
Berlin md Date signed 1/28/46
 Address...

RECEIVED

JAN 30 1946

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01071 351

1. PLACE OF DEATH: *Wicomico*
 County.....
 City or town..... *Snow Hill Rural #1*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... *45 years*
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... *Maryland* County..... *Wicomico*
 City or town..... *Snow Hill Rural #1*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... *70*

3. (a) FULL NAME *John W. Taylor*

3. (b) Social Security Number

4. Sex..... *male* 5. Color or race..... *white* 6. (a) Single, married, widowed, or divorced..... *widowed*

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... *June 3 - 1860* B. (c) If alive, give age..... years

8. AGE: Years..... *85* Months..... *7* Days..... *8* If less than one day..... hrs. min.

9. Birthplace..... *Snow Hill, Wicomico, MD*
 (Town, county, and state)

10. Usual occupation..... *Farmer*

11. Industry or business..... *Own Farm*

12. Name..... *James Taylor*

13. Birthplace..... *Virginia*

14. Maiden name..... *McBarnes*

15. Birthplace.....

16. Informant..... *Mrs. Mollie P. Pichard*

Address..... *Hocomoke City, MD Rural #3*

17. (Burial, cremation, or removal. Which?)..... *Burial* Date thereof..... *Jan. 13/46*
 (month) (day) (year)

Cemetery or crematorium..... *Bates Memorial*

Location..... *Snow Hill, MD*

18. Funeral director..... *Heame & Dumas*

Address..... *Snow Hill, MD*

19. (Date rec'd by registrar)..... *11-2-46* Registrar..... *LeRoy Smith*

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *January 11* 19..... *46* at..... *2:45* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... *July 1945* 19..... *45* to..... *Jan 11* 19..... *46*
 and that I last saw him alive on..... *Jan 9* 19..... *46*

Immediate cause of death..... *Congestive cardiac failure*
of pulmonary infarction
 Due to..... *Pulmonary embolism*
 Due to..... *Labo*

DURATION

1 wk
3 wks

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... *Robert L. La Mar, M.D.*
 M. D. or other

Address..... *Snow Hill* Date signed..... *1-12-46*

RECEIVED
JAN 16 1946
BUREAU

Jan 11 1946
C. J. [illegible]
[illegible]
[illegible]

Jan 11 1946
[illegible]
[illegible]